



How to apply -

Applying for VR services requires a series of steps:

1. An individual provides information to VR staff during an intake interview. Information requested by IDVR is necessary to begin the eligibility assessment process.

AND

2. An individual agrees that he or she is available to complete the assessment process required to determine eligibility for VR services.

AND

3. At the intake interview, the individual provides a signed and dated application signature sheet to IDVR or makes an alternative request for application to IDVR.

The application process is complete when all steps have occurred.

It is helpful to complete the attached intake form and provide it to VR at your first appointment. However, you are not required to complete an intake form to schedule an appointment or meet with a VR counselor.

Contact your local VR office if you have additional questions about eligibility requirements, the application process, or would like to apply for services.

We look forward to working with you!

*Idaho Division of Vocational Rehabilitation*



## VOCATIONAL REHABILITATION

### Intake Form

(All information is important-please complete all fields)

I am a previous VR Customer: ☐ Yes ☐ No

If Yes, Where? \_\_\_\_\_

#### **MY PERSONAL INFORMATION:**

SS#: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Middle: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Gender: ☐ Male ☐ Female Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous Last Name: \_\_\_\_\_

#### **MY ADDRESS:**

Home Address:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_

☐ Check if mailing address is the same as home address.

Home Address:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_

Primary Phone: (\_\_\_\_)-\_\_\_\_- \_\_\_\_

☐Voice

☐VP

☐Fax

Second Phone: (\_\_\_\_)-\_\_\_\_- \_\_\_\_

☐Voice

☐VP

☐Fax

E-mail:\_\_\_\_\_

**RACE (may check more than one):**

☐American Indian or Alaska Native (tribal affiliation):\_\_\_\_\_

☐Asian

☐Black/African-American

☐Hispanic or Latino (must also select a race or races

☐Native Hawaiian or other Pacific Islander

☐Not Hispanic or Latino (must also select a race or races

☐White

Are you legally able to work in the United States? ☐Yes

☐No

Do you have a driver's license?

☐Yes

☐No

Do you drive/mode of transportation? \_\_\_\_\_

**OTHER:**

Do you require communication assistance? ☐Yes ☐No

Explain:

\_\_\_\_\_

Other needs request

\_\_\_\_\_

\_\_\_\_\_

Are you your own legal guardian?

☐Yes

☐No

Legal guardian's name: \_\_\_\_\_

Guardian's phone: \_\_\_\_-\_\_\_\_-\_\_\_\_ ☐Voice ☐VP ☐Fax

CONTACTS: (Examples: Family, Friends, PO, ase Worker Etc.)

	Name	Relationship	Phone	Ext.#	Voice/VP/ Fax
1.			(____)-____-____		
2.			(____)-____-____		
3.			(____)-____-____		

What are your current living arrangements?

- |  |  |
|--|--|
| <input type="checkbox"/> Private Residence (home, apt, live<br>With family | <input type="checkbox"/> Mental Health Facility              |
| <input type="checkbox"/> Adult Correction Facility                         | <input type="checkbox"/> Nursing Home                        |
| <input type="checkbox"/> Community Residential/group home                  | <input type="checkbox"/> Other                               |
| <input type="checkbox"/> Halfway House                                     | <input type="checkbox"/> Rehabilitation Facility             |
| <input type="checkbox"/> Homeless/Shelter                                  | <input type="checkbox"/> Substance Abuse Treatment<br>Center |

**Marital Status:** ☐ Married ☐ Never Married ☐ Divorced ☐ Separated  
☐ Widowed

- |  |  |
|--|--|
| <input type="checkbox"/> American Indian VR Services<br>Program                  | <input type="checkbox"/> Center for Independent Living                               |
| <input type="checkbox"/> Child Protective Services                               | <input type="checkbox"/> Community Rehabilitation<br>Program                         |
| <input type="checkbox"/> Consumer Organizations or<br>Advocacy Groups            | <input type="checkbox"/> Educational Institutions<br>(elementary/secondary)          |
| <input type="checkbox"/> Educational Institutions (post-<br>secondary)           | <input type="checkbox"/> Employer  |
| <input type="checkbox"/> Employment Networks (not<br>otherwise listed)           | <input type="checkbox"/> Federal Student Aid (Pell grant,<br>SEOG, work study, etc.) |
| <input type="checkbox"/> Intellectual and Developmental<br>Disabilities Agencies | <input type="checkbox"/> Medical Health Provider (public or<br>private)              |

☐ Mental Health Provider (public or private)

☐ One-Stop Agency

☐ Other State Agency

☐ Public Housing Authority

☐ State Department of  
Correction/Juvenile Justice

☐ Veterans Administration

☐ Workers Compensation

☐ No Service or Funding Provided

☐ Other Sources

☐ Other VR State Agency

☐ SSA (Disability Determination  
Service or district office)

☐ State Employment Service  
Agency

☐ Welfare Agency (state or local  
government)

**Who referred you to VR?:**

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**FINANCIAL:**

Including yourself, number in household: \_\_\_\_\_

Number of Dependents: \_\_\_\_\_

**Primary source of income/financial support:**

☐ Personal Income (Employment earnings, interest, dividends, rent, retirement, and/or Social Security retirement benefits)

☐ Family and friends

☐ Public Support (SSI, SSDI, TANF, etc.)

☐ All other sources(e.g. private disability insurance, private charities, child support etc.)

SSDI Status: ☐ allowed ☐ denied ☐ pending

☐ not an applicant

SSI Status: ☐ allowed ☐ denied ☐ pending

☐ not an applicant

SSI Aged: \$ \_\_\_\_\_ VA: \$ \_\_\_\_\_ Workers Comp: \$ \_\_\_\_\_  
SSI Disabled: \_\_\_\_\_ TANF: \$ \_\_\_\_\_ Other Public Support: \$ \_\_\_\_\_  
SSDI: \$ \_\_\_\_\_

**Veteran:** ☐ Yes ☐ No

**I have one or more of the following medical insurances:**

- ☐ Not yet eligible for private insurance through a current employer, but will be eligible for private insurance after a certain period of employment
- ☐ Medicaid
- ☐ Medicare
- ☐ None
- ☐ Private insurance through other means
- ☐ Private insurance through own employer
- ☐ Public insurance from other sources

**LEVEL OF EDUCATION AT REFERRAL**

- |  |  |
|--|--|
| <input type="checkbox"/> None  | <input type="checkbox"/> Bachelor's degree   |
| <input type="checkbox"/> Elementary Education (grades 1-8)                         | <input type="checkbox"/> Master's degree   |
| <input type="checkbox"/> Secondary Education, no high school diploma (grades 9-12) | <input type="checkbox"/> Any degree above a Master's e.g. Ph.D., Ed.D., J.D                    |
| <input type="checkbox"/> Attending special education program                       | <input type="checkbox"/> Vocational/Technical certificate                                      |
| <input type="checkbox"/> High school equivalency certificate (GED)                 | <input type="checkbox"/> Occupational credential beyond undergraduate degree work (LSW, CPA)   |
| <input type="checkbox"/> Post-secondary education, no degree or certificate        | <input type="checkbox"/> Occupational credential beyond Graduate degree work (CRC, LPC, LCASW) |
| <input type="checkbox"/> Associate's degree  |  |

Graduation date for highest level of education \_\_\_\_\_

If attending high school, the name of the school is:

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What year did you start high school: \_\_\_\_\_

I am a student with a disability in high school:

☐ Yes

☐ No

I have a current 504 Accommodation Plan:

☐ Yes

☐ No

I have a current IEP:

☐ Yes

☐ No

**EMPLOYMENT:**

Last Year Employed: \_\_\_\_\_

**Employment Status at referral:**

☐ State agency-managed Business Enterprise Program (BEP)

☐ Employment with supports in an integrated setting

☐ Employment without supports in an integrated setting

☐ Extended Employment

☐ Homemaker

☐ Not working: All other students

☐ Not working: Other

☐ Not working: Student in secondary education

☐ Not working: Trainee, Intern or Volunteer

☐ Self-Employment (Except BEP)

☐ Unpaid Family Worker

If you are working, average hours worked per week:\_\_\_\_\_

Salary:\_\_\_\_\_ ☐ Hourly ☐ Monthly ☐ Annually

**My Work History:**

(Starting with most recent and include applicable volunteer work)

#1 Employer:\_\_\_\_\_

Job Title:\_\_\_\_\_

Job Duties:

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Weekly hours worked:\_\_\_\_\_ Hourly wage:\_\_\_\_\_ Start date:\_\_\_\_\_ End date: \_\_\_\_\_

Reason for leaving:

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How did you get this job:

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What duties did you do that were difficult to perform:

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Was a special license required (CNA, CDL, etc.):

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Can you return to this job? ☐ Yes ☐ No

If not, why:

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Could someone at this employment give you a reference? ☐ Yes ☐ No

Who?

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#2 Employer: \_\_\_\_\_

Job Title: \_\_\_\_\_

Job Duties:

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Weekly hours worked: \_\_\_\_\_ Hourly wage: \_\_\_\_\_ Start date: \_\_\_\_\_ End date: \_\_\_\_\_

Reason for leaving:

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How did you get this job:

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What duties did you do that were difficult to perform:

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Was a special license required (CNA, CDL, etc.):

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Can you return to this job? ☐ Yes ☐ No

If not, why:

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Could someone at this employment give you a reference? ☐ Yes ☐ No  
Who?

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#3 Employer:\_\_\_\_\_

Job Title:\_\_\_\_\_

Job Duties:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Weekly hours worked:\_\_\_\_\_ Hourly wage:\_\_\_\_\_ Start date:\_\_\_\_\_ End date: \_\_\_\_\_

Reason for leaving:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How did you get this job:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What duties did you do that were difficult to perform:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was a special license required (CNA, CDL, etc.):

\_\_\_\_\_

\_\_\_\_\_

Can you return to this job? ☐ Yes ☐ No

If not, why:

\_\_\_\_\_

\_\_\_\_\_

Could someone at this employment give you a reference? ☐ Yes ☐ No

Who?

\_\_\_\_\_

#4 Employer:\_\_\_\_\_

Job Title:\_\_\_\_\_

Job Duties:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Weekly hours worked:\_\_\_\_\_ Hourly wage:\_\_\_\_\_ Start date:\_\_\_\_\_ End date: \_\_\_\_\_

Reason for leaving:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How did you get this job:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What duties did you do that were difficult to perform:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was a special license required (CNA, CDL, etc.):

\_\_\_\_\_

\_\_\_\_\_

Can you return to this job? ☐ Yes ☐ No

If not, why:

\_\_\_\_\_

\_\_\_\_\_

Could someone at this employment give you a reference? ☐ Yes ☐ No

Who?

\_\_\_\_\_

#5 Employer:\_\_\_\_\_

Job Title:\_\_\_\_\_

Job Duties:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Weekly hours worked:\_\_\_\_\_ Hourly wage:\_\_\_\_\_ Start date:\_\_\_\_\_ End date: \_\_\_\_\_

Reason for leaving:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How did you get this job:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What duties did you do that were difficult to perform:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was a special license required (CNA, CDL, etc.):

\_\_\_\_\_

\_\_\_\_\_

Can you return to this job? ☐ Yes ☐ No

If not, why:

\_\_\_\_\_

\_\_\_\_\_

Could someone at this employment give you a reference? ☐ Yes ☐ No

Who?

\_\_\_\_\_

**Have you been convicted of a felony:** ☐ Yes ☐ No

Offense(s):

\_\_\_\_\_

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Date of Conviction(s):

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State Where Conviction(s): Occurred:

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Probation/Parole officer is:

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IDOC # \_\_\_\_\_

Date Probation Started: \_\_\_\_\_

Completion Date: \_\_\_\_\_

Restitution owed: \_\_\_\_\_

**DISABILITIES:**

**Please describe your disabilities and functional limitations:**

(Physical, Injuries, Mental Health, Depression, Substance Abuse (drug and/or alcohol), Learning Disability, etc.)

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**My disability makes it difficult to?**

**(Describe how it affects you in the space provided)**

☐ Stand   ☐ Walk   ☐ Sit   ☐ Lift   ☐ Bend   ☐ Use hands or feet

Explain:

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☐ See   ☐ Hear   ☐ Read   ☐ Write

Explain:

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☐ Concentrate   ☐ Remember   ☐ Learn   ☐ Understand

Explain:

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☐ Handle stress   ☐ Control emotions   ☐ Work with others  
☐ Communicate

Explain:

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☐ Other:

Explain:

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**How do your disabilities affect your current ability to work or keep a job?**

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**How do you think Vocational Rehabilitation can help you get a job and keep one? What are your employment needs?**

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**\*\*\*\*\*Agency Use Only\*\*\*\*\***

*Next step in establishing eligibility:*

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*Counselor additional information or comments:*

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